

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2-2-1934

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

24695

3293

1. PLACE OF DEATH

County Jackson

Registration District No. 274

Township 1st

Primary Registration District No. 1934

City Kansas City

(No. St. Joseph Hospital)

File No.

Registered No.

St.

Ward)

2. FULL NAME John H. Stravhun

(a) Residence, No. 442 S. Jackson St., Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 24, 1852

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

82

7

26

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Millwright

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Rolla Mo.

FATHER

13. NAME

Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown

MOTHER

15. MAIDEN NAME

Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown

17. INFORMANT (ADDRESS)

Fred W. Stravhun
442 S. Jackson

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Green Lawn

DATE

July 23, 1934

19. UNDERTAKER (ADDRESS)

W. H. Newcomer Sons
2111 E. 9th St. P.O. Mo

20. FILED

7-21

1934

nm

nm

Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

July 20, 1934

22. I HEREBY CERTIFY, That I attended deceased from

July 18, 1934 to July 20, 1934

Last saw him alive on July 20, 1934 Death is said

to have occurred on the date stated above, at 8:05 a.m.

The principal cause of death and related causes of importance were as follows:

Excursion cerebral arteriosclerosis

Focal areas of encephalomalacia

hypostatic pneumonia

Other contributory causes of importance:

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

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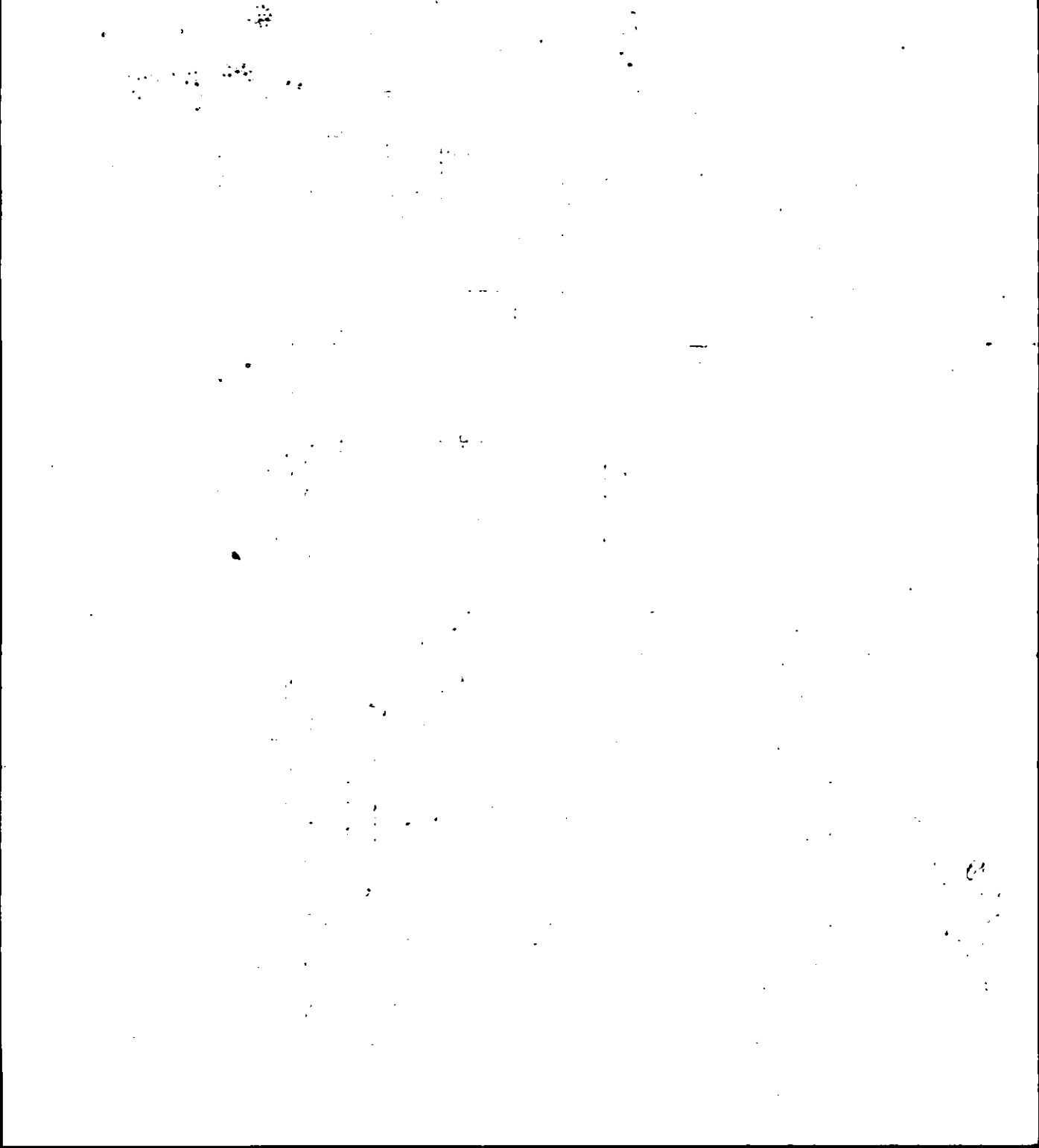
hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia

hypostatic pneumonia



#2

Kansas City

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

3293

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: John H. Strawn
Who died at St Joseph. Hosp on July-20-1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 8.2 Months 7 Days 26

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. JP

Date deceased last worked at this occupation: Month 12 Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Excessive cerebral-arterio sclerosis
facial areas of Encephalomalacia Broncho

Other contributory causes of importance Hypostatic pneumonia

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar: M. M. Cergue Date filed 7/21/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 399

Primary Reg. Dist. No. 1002

E. T. McGaugh, M.D.

Special Agent.

S-24695